Draft

Designing the 2nd phase Technical Cooperation Project (TCP) and the 3rd country training program (TCTP) for MCH Handbook in Indonesia

For Internal Discussion, Not for Citation

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Available trip reports

Dec. 2005	North Sulawesi
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Jan. 2006	Banten Province
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Road to this draft:

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May 2006	Preparation meeting for the preliminary study mission by Bureau of planning and Secretariat of Directorate of General, Public Health
May 2006	Discussion between Deputy Resident Representative JICA Indonesia office and Director General of Directorate General of Public Health
May 2006	The Third draft (current)

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Abbreviations

MOH	Ministry of Health, Republic of Indonesia
JICA	Japan International Cooperation Agency
TCP	Technical Cooperation Project
TCTP	Third Country Training Program
PDM	Project Design Matrix
R/D	Record of Discussion
Buku KIA	*Buku Kesehatan Ibu dan Anak* (MCH handbook)
MCH handbook	Maternal and Child Health handbook
Kelas Ibu	Group effort for learning for MCH guided by health personnel (Mothers' Class)
Senam Hamil	Maternity Exercise, a component of Mothers' Class
Petunjuk Teknis	Technical Guideline of MCH handbook for health personnel at health center level
Pedoman Managemen Buku KIA	Management Guideline of MCH handbook at health center level
SK Menkes	Ministerial Decree
KMS	*Kartu Menuju Sehat* (Growth Monitoring Chart/Card)
Dekon MMR IMR	Special Budget on MMR and IMR decreasing
ASKESKIN	Health Insurance for the Poor
SDKT	Indicator of Posyandu Activity

1. Introduction

The MCH handbook is a simple but powerful tool to disseminate essential MCH information and to keep basic health record at the community level. Since it was developed in the middle of 1990s, MCH handbook has been applied to wide area in Indonesia. By the end of 2005, MCH handbook is implemented in 31 provinces with more than 288 districts (MOH Family Health Directorate 2005). Ministerial decree on MCH handbook in 2004 (Kep Menkes RI No.284/Menkes/SK/III/2004) provides solid foundation for the MCH handbook and opportunity for MCH handbook to be included in the item for special budget on MCH activities from 2006 making seven provinces to use the special budget to cover 90% of estimated pregnant women in the area. However, still we have several issues to overcome if we would like to have MCH handbook functions well and sustain as national health system. To appreciate and support the effort of the Government of Indonesia (GOI), the government of Japan (GOJ) has accepted two relevant proposals regarding the MCH handbook. Those are the second phase Technical Cooperation Project (TCP) and the Third Country Training Program (TCTP). For this purpose, this document is prepared to accelerate mutual understanding on the current situation of MCH handbook in Indonesia for further designing the second phase TCP and TCTP.

1.1. Principle of the designing of the second phase

Nevertheless to say, the future cooperation should be located in the context of policy of MOH, RI. As it is clearly stated in the partnership meeting on December 15, 2005, MOH RI has prioritized the mission to reduce the Maternal Mortality Rate (MMR) and Infant Mortality Rate (IMR) by the year 2010(MOH 2005). To achieve this goal within the exact time period, four pillars are presented, those are; 1) National Initiative for social mobilization and community empowerment, 2) National initiative to improve health system performance, 3) National Initiative to Improve Surveillance, Monitoring, and Information Systems, and 4) National Initiative to Increase Health Sector Financing. These four pillars provide us the arena where MCH handbook can contribute to.

1.2. Brief history

We believe that many of the expectant readers of this document have been involved in the process of development of MCH handbook in Indonesia and share some part of the history. But still here, we would like to sum up a just brief history of the MCH handbook in Indonesia.

Starting from the Central Java province in 1994, MCH handbook has been implemented in wide geographical areas in Indonesia by the end of "The Ensuring the Quality of MCH Services through MCH Handbook Project" (hereinafter it is referred to as "MCH handbook project") in 2003. MCH handbook project was implemented during the time of 1998 to 2003. Description of the MCH handbook in Indonesia needs to start the pre-project period of 1994 to 1997, since it was formulated based on the experiences of another JICA project during 1989 to 1994 and activities of the JICA individually dispatched experts prior to 1998 in Central Java. Then, the second period is the two focused province (West Sumatra, North Sulawesi) period between 1998 and 2001. The third period is the six sub-focus province (Yogyakarta, NTB, Bali, East Java, South Sulawesi and Bengkulu) period after the Record of Discussion(R/D) was amended in 2001 up to the end of the project.

Contributing factors to the achievements is due to 1) simplicity of its concept and implementing

approach, 2) strong ownership and enthusiasm of the Indonesian side, 3) carefully revised the contents of the MCH handbook to match essential needs, and 4) collaboration with various stake-holders (JICA MCH Handbook Project Final Report 2003).

As MCH handbook implementation becomes as the national program, so far many relevant organizations have introduced it into their project area, like ADB, WB, UNICEF, WHO, World Vision and Save the Children fund. Ministerial Decree on MCH handbook in 2004 provides solid basement to put it into the national strategies to reduce MMR and IMR and allows more strategic collaboration between donor agencies.

1.3. MCH handbook in Indonesia in the international setting

If we look the MCH handbook implementation internationally, there are several countries to have experiences with MCH handbook. We could say Indonesia is in the middle stage of implementation of MCH handbook in the international settings. The first group countries, where the MCH handbook built in its health system are consisted of Japan, Korea, Thailand, the Netherlands, and some states of the United States. The second group countries, where the MCH handbook have become a part of national policy but still is seeking sustainability are consisted of Indonesia, Mexico and the Philippines. The third group countries, where MCH handbook is implemented in pilots are consisted of Bangladesh, Vietnam, Laos, and Bhutan (International Symposium on MCH handbook 2004 Dec).

1.4. Potential of MCH handbook in Indonesia

As we already noticed, MCH handbook has a potential to contribute to increase quality of services on MCH in Indonesia in several ways, such as;

- A guide for standardized MCH service
- Communication and referral tool among health personnel/health facilities
- Promote integrated and comprehensive MCH services
- Efficient and affordable (±Rp. 3,000- for 5 years monitoring and recording MCH services)
- Create an improved 2 ways communication in MCH service and IEC
- Improve health knowledge and skill of the family
- Increase mother's and family satisfaction on MCH service

As we all share the four pillars of the new MOH strategy, it is meaningful to locate MCH handbook into its context.

(1) A tool for social mobilization and community empowerment

- A tool for reproductive health rights and child rights: As a basic reproductive health right, MCH handbook tells whatever essential health services they have right to ask throughout the period of pregnancy. This provides the basement to know their health and essential information for healthy life. For child, MCH handbook would be the first book in his or her life and the first present from the society to where the child belongs to. This shows the responsibility of the society which welcomes the child as a member of the society.
- A tool for approaching community including non-access to public health services: There is a potential to use MCH handbook as a motivator to access to public health services. Payakumbuh city in the West Sumatra province asks health volunteer to be a facilitator of

MCH handbook for its distribution. Based on the observation of health personnel, if they would not have health volunteer's help, around 100% of distribution rate toward target population would be down to 80% due to its urban setting.

(2) A tool for improving health system performance

- A tool for maximizing health service performance: MCH handbook can multiply a mother's access to health facility for the optimal health intervention. For example, a mother brings one year and two month child to a health center for sickness, can be checked with its immunization schedule so that she knows when she needs to come back for immunization in case it is not finished. She also can learn how she can stimulate the child at home so that the child can be ready to walk. This is an existing case which we met in a health center in the North Sulawesi Province. We learn her needs to know when she can get complete immunization for often sick child and to know whether she needs some special consultation for not walking child by the age. But unfortunately, the mother did not bring the MCH handbook and the staff never asked her to do so, she did just get the medicine for sickness. Thos if health personnel do not bore to ask to show MCH handbook at the health services, this case shows one time visit could be multiple use.

(3) A tool for improving surveillance, monitoring, and information systems

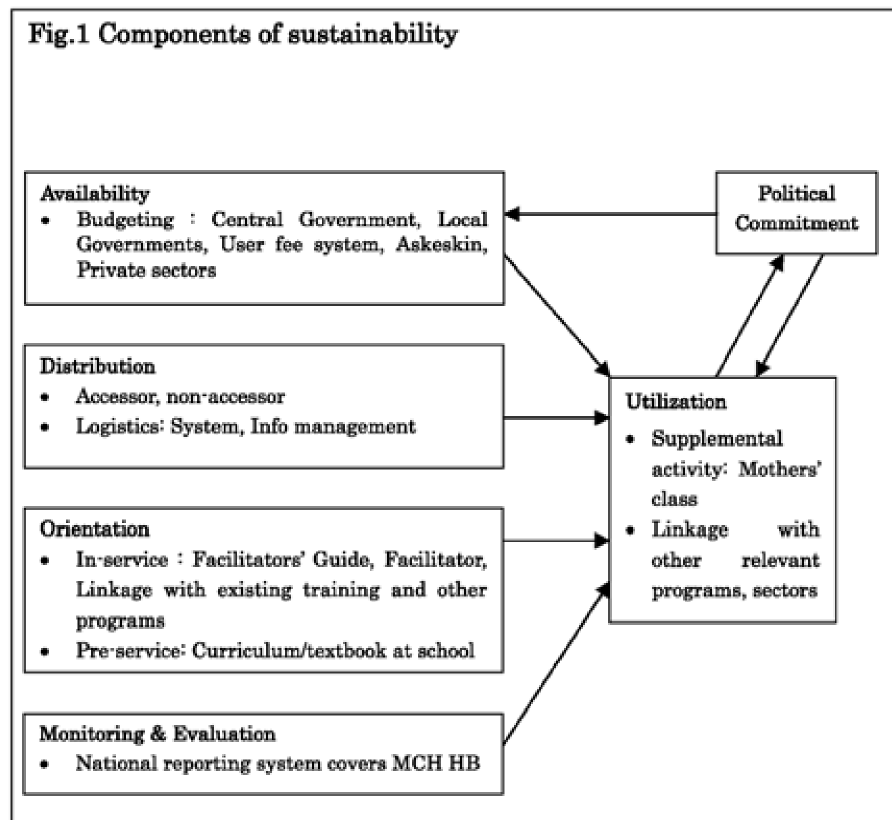
- A tool for monitoring of health condition: As MCH handbook is home-based handbook kept by mother herself, even if she changes health provider, for example, from a midwife at the health center in her village for antenatal care to a midwife clinic in her parent's village at delivery, the health record during pregnancy does not discontinue. MCH handbook can be a remainder for health personnel so that they could learn what services needed to be provided.
- A tool for monitoring health service performance: We must accept that health recording culture is weak in Indonesia. By using MCH handbook as a performance indicator, we may facilitate health personnel to fill in health record in it as well as in facility base record. It means we may facilitate health data recording through MCH handbook implementation. If the health personnel will be counted competent or good performer only when MCH handbook or facility based records are filled in, health personnel may be more positive for keeping health record.

(4) A tool for increasing health sector financing

- A tool to obtain local support for health with its simplicity: It is still challenge for us to say that MCH handbook could be a tool for the purpose. In general, health sector is a sector less invested by public rather than other sector. But MCH handbook would be the tool to attract local government for its simplicity and clear message to the benefit for mother and child. This is implicated by West Sumatra Province since they have succeeded to receive enough printing budget for covering 100 % of targeted pregnant women in the area by sharing 60% from province and 50% from district government. They use the catch phrase for advocacy, "MCH handbook is the only thing which can be reached to target directly, not like training and socialization of program." This consequently, they succeeded to facilitate local governments to show their contribution for health.

2. Situation Analysis: Where are we?

In this part, we would like to summarize current situation, the MCH handbook implementation in Indonesia. To examine sustainability of the MCH handbook implementation in Indonesia, here we are going to look into components of sustainability that is availability, distribution system, orientation, monitoring and evaluation and utilization (Fig. 1).



2.1. Availability of MCH handbook

In 2003, the last year of the 1st phase project of MCH handbook, around 2.5 million handbooks were prepared in total and about 50% of them were from JICA. After experiencing shortage of MCH handbook, from 2006, coverage is going to be up to about 60% (around 3 million handbooks) without funding by JICA. This shows strong willingness of Indonesian government to sustain MCH handbook (Fig. 2). We must realize the regional variety of availability of MCH Handbook as mentioned in the Table 2. Thanks to the special budget on MMR and IMR decreasing (Dekon MMR and IMR), from 2006, some places will have MCH handbook again after several years' shortage, or many places will newly start MCH handbook implementation (Table 3).

The Ministerial Decree on MCH handbook states clearly about the responsibility of local governments both province and district health office for availability of the MCH handbook. District level local governments are highly appreciated if they put their priority on MCH handbook in this decentralized settings. Provincial office is asked to be a buffer of district levels and to make coordination of reprinting so that they have relevant unit price of MCH handbook. From the central government, the standard content of MCH handbook is provided by CD-ROM with PDF file. This CD-ROM contains the Ministerial Decree to facilitate local governments' contribution to reprint the MCH handbook, as well as necessary relevant technical guidelines which are also mentioned in the Ministerial Decree (*CD-ROM Buku KIA 2005*).

Some local governments have started to introduce charging system for MCH handbook. It would be an alternative to maintain MCH handbook availability since charging could raise senses of belongings, in other words, ownership of MCH handbook by the client. For charging, local governments are recommended to have written legislation with management system. As private sector, Indonesian Midwife Society (IBI) has another effort for availability at private sector. They provide MCH handbook for private sector by selling it for 5,000 rupiah each.

(For more detail, please refer *Situation Analysis of the implementation of MCH handbook in Indonesia in 2005*)

Fig.2 Printing Coverage of MCH handbook

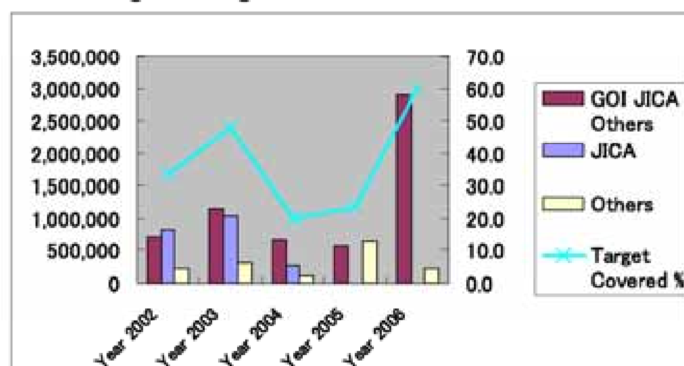


Table 2 Regional variation of budget of printing of MCH handbook (2005)

		Provinces
75%=< (2 provinces)		Aceh・Bali
50%=< (2 provinces)		West Sumatra・Yogyakarta
25%=< (7 provinces)		Lampung・NTB・South Kalimantan・Central Kalimantan・East Kalimantan・North Sulawesi ・Central Java[1]
<25% (20 provinces)	10%<	East Java[2]・North Sumatra・Banka Bulitung・South Sulawesi (4 provinces)
	5%<	West Java・Jakarta・West Kalimantan・Central Sulawesi・Maluku (5 provinces)
	0%<	Riau・Jambi・Bungkulu・ Papua (4provinces)
	0%	South Sumatra・Banten・Golontalo・South east Sulawesi・North Maluku・Riau islands・NTT (7 provinces)

Table 3 Regional variation of budget for printing of MCH handbook (2006) based on planning

		Provinces
75%=< (14 provinces)		North Sumatra・West Sumatra ・South Sumatra・Bungkulu・Lampung・Banten・Bali・Central Surawesi・North Surawesi・Golontalo・Maluku・NTT・ North Maluku・Riau islands
50%=< (11 provinces)		Riau・Jambi・Banka Bulitung・West Java・Yogyakarta・East Java・NTB・Central Kalimantan・South Kalimantan・East Kalimantan・Papua
25%=< (1 province)		Central Java (1 province)
25%> (5 provinces)	10%<	Jakarta・South East Sulawesi・West Kalimantan・South Sulawesi (4 provinces)
	5%<	Aceh (1 provinces)

[1] Based on the assumption that districts in the Central and the East Java provinces cover printing as much as the year 2004.
[2] Ditto

Table 4 Regional variation of budget for printing of MCH handbook (2006) based on the newest information as of the end of April 2006

	Provinces
90%=< (9 provinces)	Riau, West Sumatera, South Sumatra, DKI Jakarta, Bali, NTB, Central Kalimantan, North Sulawesi
75%=< (1 province)	East Java
50%=< (5 provinces)	Aceh, Lampung, West Kalimantan, NTT, Papua
25%=< (7 provinces)	Jambi, East Kalimantan, Banten, West Java, Central Java, Yogya, Gorontalo
25%>	North Sumatra, Riau Islands, South Sulawesi
N.A.	Bungkulu, Bangka Bulitung, South East Sulawesi, North Maluku, Maluku, West Papua

2.2. Distribution

Distribution of MCH handbook is following the administrative flow of public health services. It is carefully distributed to targeted pregnant women by health personnel with stock management system. This is done based on lessons learned from Growth Monitoring Chart (*KMS*) card distribution. We could say that MCH handbook is distributed more carefully than KMS card, by making sure to be filled in by health personnel and avoiding duplication of distribution (*Petunjuk Teknis Buku KIA*).

As an indicator of MCH handbook implementation, distribution of MCH handbook is recommended to be equal (or bigger than) to the number of pregnant women who ever accessed to health facilities for Antenatal Care (K1 in wide definition) (*Petunjuk Teknis Buku KIA*). However, we do not much enough information to judge distribution rate of MCH handbook due to lack of data. Only we could assume that it would not be enough due to limited number of available MCH handbook.

Distribution at hospital service and at private sector is still challenge for MCH handbook implementation. Hospitals should start to use MCH handbook. Private sectors, like private clinics by midwives have started to distribute it with charge.

2.3. Orientation

As in-service training, orientation of MCH handbook to relevant health personnel is variously done among provinces. Some have done special training session to their personnel, while others have not done only socialization to their personnel and health personnel learn technical guidelins by their selves. In general, the set of guidelines helps them as their guidelines (*Petunjuk Teknis Buku KIA, Pedoman Managemen Buku KIA*).

For pre-service education, some provinces have already put it into their academy education. But we must say those efforts have been done locally (West Sumatra 2005). Therefore we could say that there is variety of degree of orientation towards health personnel. But in general, health personnel other than midwife has never been trained nor oriented to utilize MCH handbook in their work.

2.4. Monitoring and Evaluation

In the monitoring and reporting format for MCH services, it is recommended that they can check the distribution of MCH handbook (*Petunjuk Buku KIA, Pedoman Managemen Buku KIA*). It is also recommended that in the existing health record (*Kohort ibu*), they check a certain

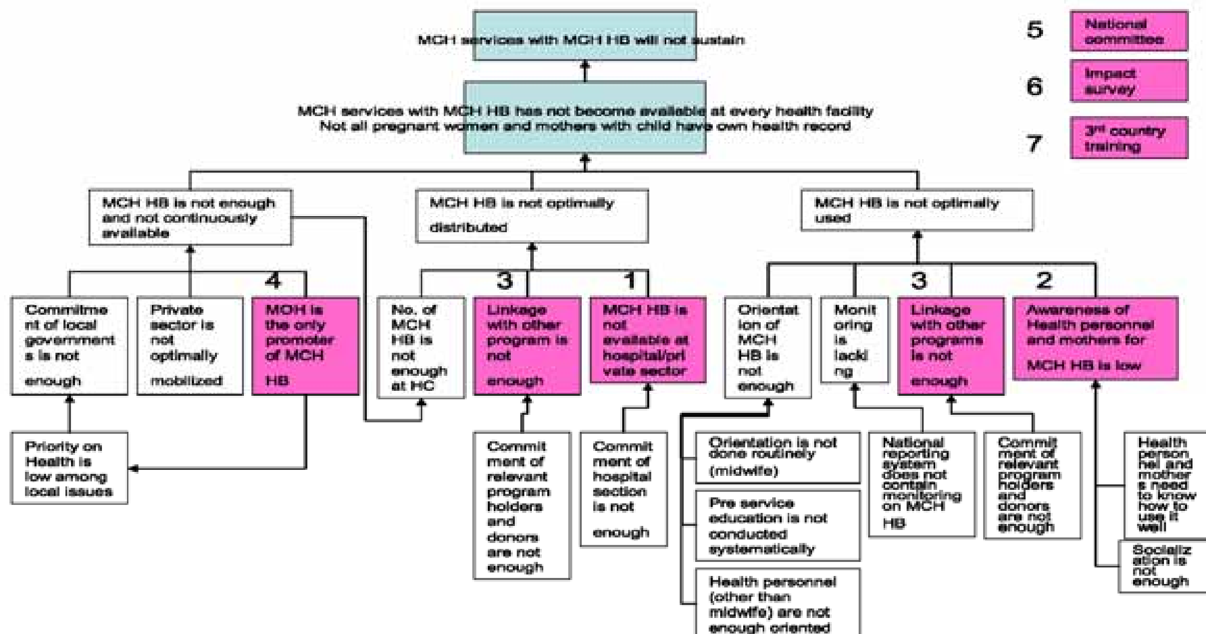
woman has already received the MCH handbook or not. Where recipients of MCH handbook are asked to contribute some thousands of rupiah for the MCH handbook, usually they have system and forms for management of collected money under the local government regulation.

We could say there is a variation between areas whether they have complete set of monitoring and reporting system on MCH handbook implementation. Especially in the decentralized setting, it is common less information is available at provincial level. Annual national review meeting is the best effort to obtain the situation at the national level as well as the provincial level. But for the above reason, not all provinces have succeeded to grasp the degree of program progress. Then not all provinces have responded to the request of the central government to submit the data.

2.5. Utilization

We must say MCH handbook has not been utilized in optimal way in many places. We need to know the reasons and how to overcome them. In general, during the pregnancy period, whenever they are sick or healthy, MCH handbook is brought to the health services by expectant mothers. However, for child care, it is common that MCH handbook is brought to the health check up and immunization services but not for sick care. Lessons learned from the field, if health personnel keep asking mothers to bring it for sick care, mothers started to bring it (South Sulawesi 2006). It means that if mothers are not motivated well to bring it for sick care, we can assume health personnel has not yet motivated mothers.

Fig. 3 Problem Analysis of MCH handbook in Indonesia



Is MCH handbook too much for Indonesian settings where many mothers are not ready to read the book, or is it too big burden for health personnel to utilize it in the very busy settings? We would like to say "No" to both questions, since many field experiences have taught us those are not necessarily true. We would like to share our observation that if we heard many complains from health personnel about the laziness and unwillingness of mothers toward MCH handbook, it could be a negative indicator of awareness of health personnel themselves toward MCH handbook.

If they are not confident or aware the benefit of MCH handbook for their own benefit, they do not explained well about MCH handbook to their client. On the other hand, once health personnel become well aware of the benefit for themselves, mothers tend to believe the benefit of MCH handbook. Moreover, mothers who have better knowledge and attitude tend to have been well informed by health personnel and to have positive utilization of MCH handbook by themselves (Agustin 2006). To raise awareness of health personnel and mothers as well, group learning effort, so called Mothers' Class could be a potential for both parties.

2.6. Conclusion of situation analysis -What do we have, so far?

As we have all provinces and more than half of districts/municipalities already have started to utilize the MCH Handbook, we have enough familiarity and acceptance of the MCH handbook in nation wide of Indonesia. But as a national system, we need to realize that what remains to be done. So we would like to list up what we have done and what we have so far, since it is the start for us to know what we need to do for the next.

(a) Ministerial Decree on MCH handbook

Ministerial Decree on MCH handbook in 2004 is a high commitment of Ministry of Health. This provides us solid foundation to implement MCH handbook, which can be used for a tool for advocacy to local governments. This provides us to make coordination between different programs and different project done by different donor agencies. Ministerial Decree on MCH handbook contains: 1) MCH handbook is the only home-based record starting from pregnancy to under 5 years, 2) Responsibility of health personnel to fill in, 3) Responsibility of governments for availability, 4) Other relevant technical guidelines (*Petunjuk Teknis, Pedoman Management*).

(b) Put into Ministerial Strategy and Policy

Special Budget on MMR and IMR covers MCH handbook availability. To answer 4 pillars set by MOH, relevant directorate covers necessary activities with MCH handbook. For example, the Directorate of Maternal Health would like to use MCH handbook as a tool for facilitate mothers to access health services. The Directorate of Child Health would like to use MCH handbook as a tool for monitoring. And the Directorate of Community Nutrition would like to use its contents of Growth Chart (KMS) as substitute of their original Growth Monitoring Card (KMS).

(c) All 33 provinces are ready to have MCH Handbook

Using the opportunity for special budget on MMR and IMR, 7 provinces have already put the necessary budget for MCH handbook printing to cover more than 90% of targeted women. This is the evidence that they prioritize availability of MCH handbook. West Sumatra province does not belong to these 7 provinces since it has already local commitment to use the local budget (APBDII and APBDI) and it did not need to apply for the special budget in terms of MCH handbook reprinting.

(d)Some local efforts for availability

We have several districts and provinces where have succeeded to obtain high local commitment for availability. For example, West Sumatra Province has high local commitment for availability covering 100 % of targeted women by sharing 60% from province and 40% from districts,

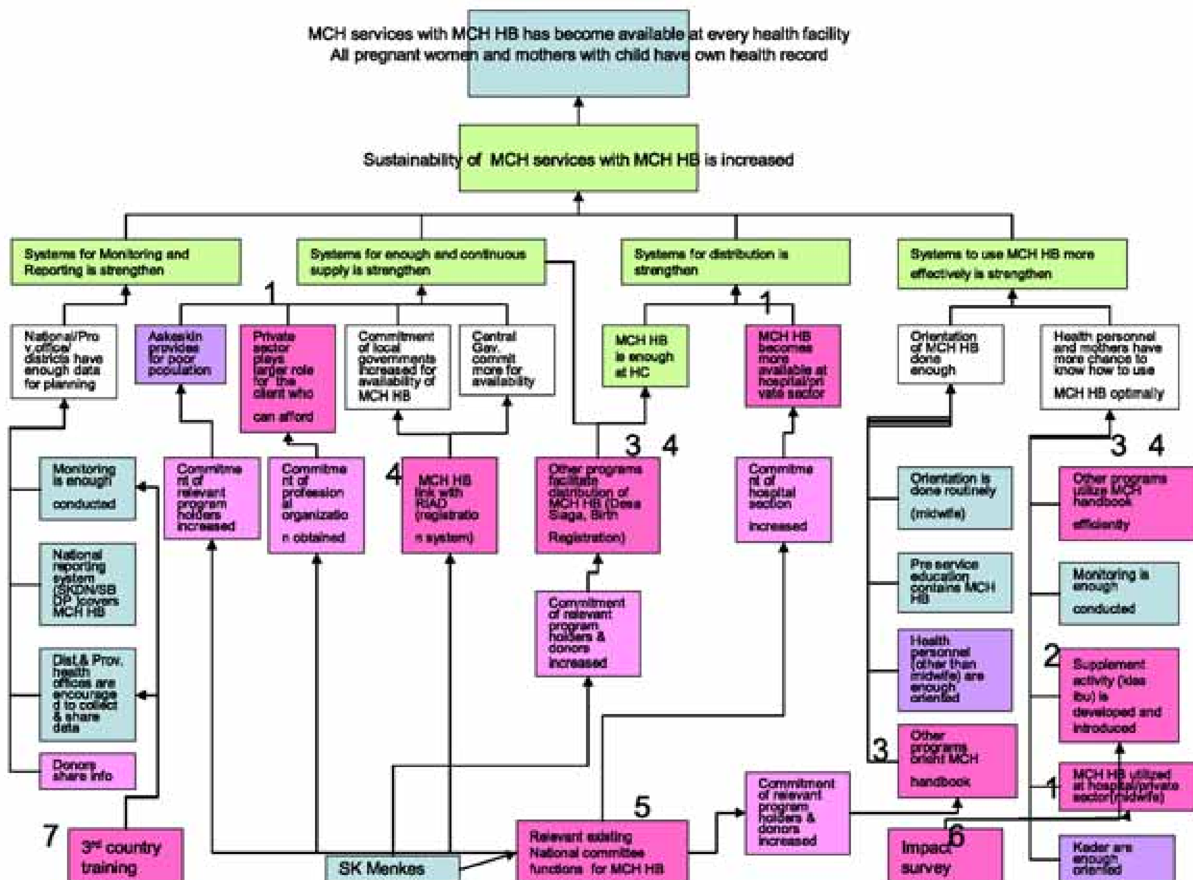
(f) Efforts for better utilization

Several efforts have been done in various places. For example, West Sumatra province has developed a group learning effort called "Mothers' class (Kelas ibu)" to learn the contents of the MCH handbook, besides interesting activities such as "Maternity Exercise (Sunam hamil)". They also have experiences of integration of pre-service training (written syllabus for Midwife Academy), reporting system within existing recording (*Kohort ibu, Register Pelayanan puskesmas* and stock management) and integration of hospital services in MCH handbook implementation.

3. Current Issues –what do we need to have?

In this part, we would like to summarize what we need to pursue if we would like to have solid implementation of MCH handbook in the national health system.

Fig. 4 Objective Analysis of MCH handbook in Indonesia



3.1. Availability of MCH handbook

To ensure availability of MCH handbook, we need to have a strategy to cover about 5 million pregnancies every year. First, we need to realize that 30% of pregnant women belong to the poverty group in Indonesia and they are the target population of "Health Insurance for the Poor (*ASKESKIN*)". They are going to be supported by the government for 250,000 rupiah per each delivery. If we see the person in grey zone, those who belong to marginal, 40% of all pregnant women belong to this group. We need to promote MCH handbook to the program holders who manages *ASKESKIN* to cover 30-40% of total population.

Second, we need to realize that some effort in the district level has succeeded to obtain local commitment for availability of MCH handbook. In the most committed place, West Sumatra Province, 40% are provided by districts and 60% by provinces. We could assume that it would be the best practice of high local commitment on MCH handbook and it would be realistic we set the line of 40-50% of total population provided by the local government. This number will be able to include some efforts of charging at public health facilities as well as some effort by private practitioners through midwife networks, which provide the MCH handbook to the women who

can afford it.

Third, the remaining 10-30% is to be the responsibility of the central government as the buffer of the availability in the nation wide.

Moreover, we also need to realize that Ministry of Health is the only promoter of the MCH handbook in Indonesia so far. To get political commitment for the availability, we need to make the MCH handbook attractive to other than Ministry of Health. For example, MCH handbook could be linked with birth and death registration. If so we need to have a strategy to link with the effort of Ministry of Home Affairs such as RIAD.

To make these things realities, we need to have several efforts in the 2nd phase project, especially to obtain commitment of the program holders and relevant parties would be the essential to this.

3.2. Distribution

As we already discussed above, to ensure the distribution at the public health sector, we need to ensure the availability of MCH handbook first. However it would not be enough to have enough distribution rates. It is necessary to count the distribution of MCH handbook as a basic service component of the Antenatal Care like other indicators such as "5T". And to ensure this, existing reporting and monitoring format should covers MCH handbook distribution.

Also as mentioned above, distribution at hospital service and at private sector is still kept as challenge. Hospitals should start to use MCH handbook for the referral cases, then they are also asked to have a function of distribution. Private sectors, like private clinics by midwives have potential to have larger functions to distribute the MCH handbook, to those who do not access to public sector but to private sector. We may start to discuss with midwife association about their potentials and weakness for distribution.

3.3. Orientation

We may have several focusing areas. First, we need to be sure that the midwife, the entry point of the MCH handbook, should be oriented its benefit and usage of MCH handbook well. It is essential and it should be done systematically and routinely in the context of in-service training. It is not necessarily to be done separately from the other trainings but it should be located in the existing or optimal in-service training context. For pre-service education, not locally but nationally, MCH handbook should be put into syllabus of the relevant medical schools, and academies.

Second, we need to make efforts to have MCH handbook not kept only as midwifes' book but as all health personnel belonging. In maternal care, midwife is the focal point for the whole care, but in child care, more various specialties are needed in general. So we need to realize that health personnel other than midwives have not been exposed well to MCH handbook and most of them have not realized that usage and filling in MCH handbook is a part of their responsibility as written in the Ministerial Decree.

Third, to be close to mothers, health volunteers need to know about benefit and the usage of MCH handbook as well. As we have focused more on health personnel, we need to have several efforts to facilitate health volunteer especially in the area, where health personnel is not enough.

3.4. Monitoring and Evaluation

Monitoring and Evaluation is essential to any kind of intervention and implementation to know the reality and to ensure the quality. However, as we discussed above, it is one of the toughest jobs to be achieved especially in the decentralized settings.

First, implementation indicators of MCH handbook could be put in the existing reporting and monitoring format like *PWS KIA*. And also implementation indicators could be put in the existing program monitoring indicator like "*SDKT (Semua, Datang, Bawah KMS, Timbang)*". SDKT could be replaced by "*SDBPIA (Semua, Datang, Bawah Buku, Pelayanan Ibu dan Anak)*".

Second, it is needed that monitoring and evaluation of the MCH handbook implementation becomes more attractive for the persons who are in charge. The central government and the provincial offices need to give enough feed back and the coming project office need also support this technical feedback flow.

Third, monitoring and evaluation activity will be motivated when they have any chance to share it with outsiders like guest from outside to learn from their experiences. For this reason, the 3rd country training (TCTP) is expected to provide arena for sharing.

3.5. Utilization

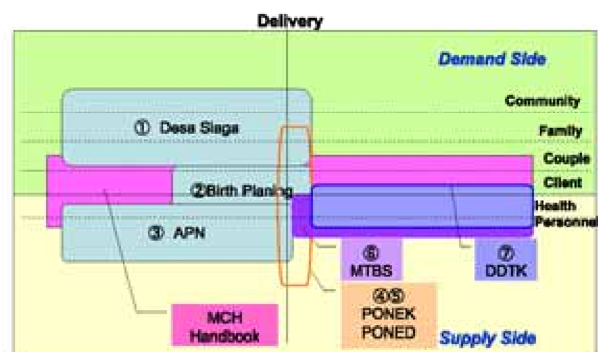
To optimize potential benefit of MCH handbook, we need to raise awareness of health personnel as well as mothers toward the benefit for MCH handbook for their own. For the purpose, we need to increase the opportunity for them to learn about it.

First, "Mothers' Class" is a good opportunity for both parties to learn about it. By setting group learning effort, health personnel have chances to learn more about their client as well as to promote their specialties for their client. Mothers have chances to learn what and where they can get necessary information in the MCH handbook whenever they need it (NTB 2006). This group learning effort needs communication skill of health personnel, so it could be put it into the context of KIP-K. As the West Sumatra could be the facilitators of other provinces for current Mothers' Class, it is a good way to promote them as a facilitator of Mothers' Class.

As current Mothers' Class has a series of contents for pregnant women covering 1) cautions for pregnant women, 2) preparation for delivery, and 3) care for newborn. There is a demand to develop a series of contents for child care covering 1) child nutrition, and 2) child development. As current Mothers' Class is designed to be conducted by health personnel (midwife), we need to have discussion on whether or how we will prepare for the version for health volunteers.

Second, with other relevant programs, MCH handbook should be integrated. For example, in the *Desa Siaga* program, MCH handbook could be a tool of health education for communities and a tool of notification of pregnant women. For the *Birth Registration* program, MCH handbook could be a tool to increase demand of community to come and register their baby at the local government office.

Diagram: Integration relevant programs based on MCH handbook



Third, usage at other health facilities like hospitals and private sectors will increase the opportunity for mothers to learn the benefit.

For these purposes, we need to have commitment of stake holders at the central

level including relevant professional organizations. And all above efforts need to be linked with evaluation activities so that we could know effectiveness of the efforts.

4. Designs of the 2nd phase TCP and TCTP

4.1. Assistance Objective and Focus of the project

Mission of Japanese Government on Overseas Cooperation is to assist recipient governments to cope with current existing unavoidable problems for the better life of human beings. Adding to the principle to comply with national policy of RI, we could mention several principles for the second phase project, those are; 1) to increase MCH service quality through maximizing potential of MCH handbook, 2) to support sustainability of MCH handbook implementation.

As based on discussion with relevant stake holders in MOH, we have a list of cooperation area in the project as follows.

1) To be utilized at hospital (and private sector)
2) To optimize KIE and monitoring function of MCH handbook (through "Klas Ibu" for maternity and child)
3) To be integrated/implemented with Desa Siaga
4) To link with register system of pregnancy, birth and death (to link with RIAD) -> Depdagri
5) To have National Committee (KesPro) covers MCH handbook issues in Indonesia (Professional organization, University, Other dept)
6) To survey the impact of MCH HB on improvement of MCH
7) To share experiences of MCH HB on improvement of MCH are shared effectively (The 3rd country training)

4.2. Narrative Summary of the Project (TCP)

(a) Overal Goal

1) MCH services with MCH handbook become available at every health facility
2) All pregnant women and mothers with child have own health record

(b) Objectives

Sustainability of MCH services with MCH handbook is increased

(c) Output

1) More sectors participate for availability of MCH handbook
2) Distribution at public health sectors (HC) and private sector increased
3) Orientation of MCH handbook is done systematically for relevant personnel
4) Health personnel and mothers have more chance to know how to use MCH handbook for optimal benefit
5) Relevant existing National Committee and necessary working groups functions for MCH handbook
6) The impact of MCH handbook on improvement of MCH is surveyed
7) Experiences of MCH handbook on improvement of MCH are shared effectively (The 3rd country training)

(d) Activities

1-1 To advocate ASKESKIN
1-2 To advocate Professionals
1-3 To advocate Ministry of home Affairs for RIAD
2-1 To increase distribution at public health sectors (HS)
2-2 To increase distribution at midwife private clinic
3-1 To monitor routine orientation for midwife

3-2 To monitor pre-service education covers MCH handbook
3-3 To facilitate other programs orient MCH handbook
4-1 To monitor usage by various health personnel
4-2 To have supplement activity (Klas Ibu)
4-3 To facilitate other programs utilize MCH handbook
4-4 To facilitate hospitals to utilize MCH handbook
4-5 To orient MCH handbook to health volunteer
5-1 To have national committee discuss on contents, impact survey, linkage with RIAD, and Logistic system
5-2 To organize and run working group on integrated pregnancy care(Klas Ibu, Desa Siaga)
5-3 To organize and run working group on health promotion for child health (Kelas Ibu)
5-4 To organize and run working group on the 3rd country training
6-1 To have impact survey concept and design
6-2 To conduct operational research at hospital setting
6-3 To have operational research at field setting (Klas Ibu)
6-4 To feedback the result of Impact Survey to policy making and implementation process
7-1 To implement the 3rd country training

4.3. Possible JICA schemes to support MCH handbook in Indonesia

1) Technical Cooperation Project (3 years)

Based on the proposal by MOH (2004), the 2nd phase for the Technical Cooperation Project (TCP) for 3 years has been accepted by Japanese Government. This TCP is the continuing phase of the 1st phase ("Ensuring the quality of MCH services with MCH handbook 1998-2003"). TCP contains 1) Dispatch of Technical Experts, 2) Procurement of equipment, and 3) Training in Indonesia and Japan. Each TCP is implemented in accordance with a Record of Discussion (R/D) to be signed by the host country and Japan when the project is initiated. Tentatively, it is planned to be launched from September 2006 for three years.

2) The 3rd Country Training Program (5 years)

Based on the proposal by MOH (2005), the 3rd Country Training Program (TCTP) for Integrated MCH services with MCH handbook for 5 years has been accepted by Japanese Government. By turning host provinces every year, 5 provinces would be a host to accept international attendants as well as local (Indonesian) attendants for the course. 30% of total training expenses shall be borne by the host country and the remaining 70% of total expenses shall be born by Japan.

3) MCH International Training Course in Japan (Every year)

Besides TCP scheme, JICA facilitates counterparts of GOI to attend other relevant International Group Training Course in Japan held by JICA. For example, in 2006, two participants from the Maternal Health Directorate and the Child Health Directorate each are going to be sent to Japan to attend "Seminar on reduction of child deaths and International Cooperation- in focus of Millennium Development Goals, No.4,5, and 6 May 8-June 25, 2006)".

4) Junior Expert (Upon request)

Based on the proposals by local governments, JICA has been dispatching Junior Experts to local

governments for activities related to MCH handbook. By the end of March 2006, 25 Junior Experts (16 midwives, 2 nurses, 6 nutritionists, and 1 public health nurse) have been dispatched and as of April 2006, 7 Junior experts are working in 6 districts in 5 provinces (NTB, South Sulawesi, Central Java, Yogyakarta, Jakarta) and Lampung provinces has proposed to JICA for 2 junior experts.

Table 5 Overview of JICA schemes

	GOJ	GOI
Dispatch of Technical Expert		
• Long term for TCP (36 mm)	XXXX	
• Short term for TCP (22.5 mm)	XXXX	
• Short term for the 3rd country training (5mm)	XXXX	
• Junior Experts (upon request)	XXXX	
• Tax Exemption for Experts		XXXX
• Provision of Experts Office		XXXX
• Assignment of Daily C/P Personnel		XXXX
Provision of equipment		
• Procurement	XXXX	
• Tax exemption, Local Transportation		XXXX
• Operation and Maintenance		XXXX
Meeting expenses		
• Core Team		XXXX
• Working Group		XXXX
• National Committee activity on MCH handbook	X (Outside from MOH)	XXX(MOH)
Training expenses		
In Indonesia		
• Honoraria		
➢ Internal Lecturer		XXXX
➢ External Lecturer	XXXX	
• Employment fee		
➢ Facilitators	XX(Outside from MOH)	XX(MOH)
➢ Support staff	XX(Outside from MOH)	XX(MOH)
➢ Trainers	XX(Outside from MOH)	XX(MOH)
• Travel Expenses		
➢ Transportation for study tour	XXXX	
➢ Trip Allowance for External Lectures	XXXX	
• Meeting Expenses		
➢ Opening Ceremony	XXXX	
➢ Closing Ceremony	XXXX	
➢ Committee Meetings		XXXX
• GI(General Information) Printing	XXXX	
• Textbook		
➢ Training Manuals	XXXX	
➢ Training Kit	XXXX	
➢ Lecture Materials	XXXX	
• Electricity and Water consumption		XXXX
• Use of Facilities and equipment		XXXX
• Others		
➢ Communications		XXXX
Training expenses		
In Japan		
• Travel Expenses	XXXX	

5) Other sources

Besides JICA scheme, other relevant information supported by other resource would be

introduced to the Government of Indonesia. For example, the 5th International Symposium on MCH handbook is going to be conducted in Vietnam on November 2006.

4.4. Project Setting

The 2nd phase TCP will be organized by the project office at Jakarta. The project will have several districts to intervene but not whole several provinces like the 1st phase of TCP. Districts will be chosen from the candidate of the host of TCTP. Those provinces and districts will have activities under the support of TCP. Criteria for selection of the provinces and the districts could be as follows.

- Commitment of provincial and district personnel
- Relevant to theme of the TCTP
- Priorities of 100 districts on high MMR and IMR

Project formation in relation with International Training

	2006 Sep-Aug	2007	2008	2009	2010
(Prov.1)	*IT:MCH handbook in Indonesia and hospital integration*	Mothers' Class (Child) development			
		IT:Private mobilization & Integration with Desa Siaga			
	Mothers' Class (Pregnant) implementation	Mothers' Class (Child) development	*IT: Child Health with MCH handbook*		
(Prov.2)		Notification and registration with MCH handbook		*IT: Notification and registration with MCH handbook*	
					IT: Community Development?
Central Model Activities	Integration of ANC trainings				
	Mothers' Class (Nutrition, Development)				
	Notification/Registration				

4.5. The Management Plan

Relevant core team and working groups need to be organized to precede necessary procedure and implement project activities. Core team would have multi directorial members consisted of Directorate of Maternal Health, Directorate of Child Health, Community Nutrition, Community Health and the Center for Health Promotion. According to certain issues for relevant each tasks like for 1) National Committee, 2)Integrated pregnancy care with Klas Ibu and Desa Siaga, 3)Health promotion for child with Klas Ibu and 4)the 3rd country training. National Committee here means that among existing national committees, one of the relevant national committee such as KesPro: Health Promotion is expected to cover issues regarding MCH handbook sustainability like 1) Standard contents, 2) Logistics of MCH handbook, 3) Linkage with RIAD, and 4) Impact Survey.

4.6. Performance Requirements

Project is to be managed with Project Design Matrix (PDM) which is mutually understood in the process of Record of Discussion(R/D) between the both governments. PDM includes the overall goal, the objectives, the activities of the project. Performance indicators are to be indicated in the PDM as well. The PDM would be revised if necessary mutual understandings

4.7. Steps for the Project (TCP and TCTP)

	4	5	6	7	8	9	10	11	12	1
Discussion with Dir.Gen.	X									
Preliminary Study Mission Feasibility, Process		X								
Core Team Meeting 1) : Draft PDM, Draft TOR working groups		X								
Core Team Meeting 2) : Meeting with Provinces			X							
Study Mission National Committee+Donor			X							
Core Team Meeting 3): R/Ds discussion				X						
Meeting R/D Agreement for TCP R/D(Budget Plan+GI) for TCTP) A1 form					X					
Project(TCP) Launching						XXXX				
GI for TCTP (Indonesia→ Candidate Countries)						X				
The 1st Training (TCTP)										X

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